



Maine Center for Disease Control and Prevention

Lyme Disease Case Report Form

Patient Information

Last Name: _____ First Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female

Race: ☐ White ☐ Black ☐ Amer. Indian/Eskimo ☐ Asian/Pacific Islander ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Symptoms and Signs of Current Episode: Please Answer Each Question

		Yes	No	Unk
Dermatologic:	Erythema migrans (physician diagnosed EM at least 5cm in diameter)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatologic:	Arthritis characterized by brief attacks of joint swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic:	Bell's palsy or other cranial neuritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Radiculoneuropathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lymphocytic meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Encephalitis/Encephalomyelitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	CSF tested for antibodies to <i>B. burgdorferi</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Antibody to <i>B. burgdorferi</i> higher in CSF than serum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiologic:	2 nd or 3 rd degree atrioventricular block	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date of Onset of First Symptoms: ____/____/____ Date of Diagnosis: ____/____/____

Was the patient hospitalized? ☐ Yes ☐ No ☐ Unk

If yes, hospital: _____

Pregnant at time of diagnosis? ☐ Yes ☐ No ☐ Unk

Where was the patient exposed? Town: _____ County: _____ State: _____

Laboratory Findings

- Please send a copy of all Lyme disease testing.
- Without laboratory report, form will be incomplete and not counted, except when Erythema migrans is present.

Diagnosis (Please Check One Option)

- ☐ Yes, this patient has been diagnosed with Lyme disease.
- ☐ This patient is still undergoing evaluation. Please contact me again in ☐15 ☐30 ☐60 days.
- ☐ I do not believe this patient has Lyme disease.
- ☐ Please contact the following health care provider to obtain information about this patient:

Other Provider's Name: _____

Physician/Reporter Information

Physician's Name: _____ Telephone Number: _____

Address: _____ City: _____ State: _____

Person Completing Form: _____ Telephone (if different): _____